

## **KHN's 'What the Health?'**

**Episode Title:** Paging the HHS Secretary

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**Julie Rovner:** Hello, and welcome back to KHN's "What the Health?" I'm Julie Rovner, chief Washington correspondent for Kaiser Health News. I'm joined by some of the best and smartest health reporters in Washington. We're taping this week on Thursday, Feb. 3, at 10:30 a.m. As always, news happens fast, and things might have changed by the time you hear this. So here we go. Today, we are joined via video conference by Alice Miranda Ollstein of Politico.

**Alice Miranda Ollstein:** Good morning.

**Rovner:** Margot Sanger-Katz of The New York Times.

**Margot Sanger-Katz:** Hello.

**Rovner:** And Rachel Cohrs of Stat News.

**Rachel Cohrs:** Hi, Julie.

**Rovner:** Later in this episode, we'll have my interview with my KHN colleague Noam Levey, who reported and wrote the latest KHN-NPR Bill of the Month about a very large bill for a very small amount of medical care. But, first, this week's news. We're going to start with somebody that we haven't talked about very much on this podcast lately, which when you think about it seems kind of odd, Health and Human Services Secretary Xavier Becerra. There have been a spate of stories recently about how Becerra has been missing in action, particularly on covid, which frankly also strikes me as a little odd because the White House made it pretty clear from the beginning that they, not the Department of Health and Human Services, were going to run covid policy. And if you'll recall, Becerra didn't even get approved until well after the administration got going last year. Becerra has been quite upfront on things like the Affordable Care Act, which is having record enrollment, and I did notice he was front and center at the relaunch of President Biden's "cancer moonshot" on Wednesday. So [here] comes my question to the panel: Should Becerra have been doing more to coordinate covid efforts of the [Food and Drug Administration], [National Institutes of Health], and [Centers for Disease Control and Prevention]? Or is the White House looking for a scapegoat for their covid woes?

**Ollstein:** I think more than just the White House. I think lawmakers also are looking for a subject to vent their frustrations, and we covered a letter from House Republicans to Becerra demanding documents and information about his whereabouts since being confirmed: who he has met with and everything.

**Rovner:** Did he take private planes places? I've read that is the subtext of the letter.

**Ollstein:** Yeah. Well, what I read as the subtext of the letter is this is going to be something that Republicans might go all in on if they win the majority, in terms of oversight and really going after Becerra and other health officials for their actions or inactions related to the pandemic, that the writing on the wall is there. And so we're tracking it for that reason, as a sign of what's to come, potentially.

**Rovner:** I couldn't help thinking when I was reading some of these stories: What if Becerra had inserted himself into all of this and tried to have everybody at the CDC and the FDA and the NIH report to him before they reported to the White House and made it even more cumbersome? I would have thought the

stories would have been even more critical and probably deservedly. This struck me as a “boy, you really can’t win here” story.

**Sanger-Katz:** I’m reminded in reading the coverage — and I have to admit I have not done a ton of reporting on this, so I don’t know exactly what’s going on behind closed doors. But there were a lot of echoes of what happened in the Obama administration with the rollout of Obamacare, which I think was also a very important signature policy push of the administration. And I think in part because it was so important, it was being run out of the White House. The White House really had its fingerprints all over everything. There was a view by people further down the chain that they had to run everything by the White House before they did it. And Kathleen Sebelius, the HHS secretary, although she was involved, I think really was sidelined. And there was, I think, a lack of coordination among the various people inside of HHS who could have enabled a really successful launch. And we all know how that went. And she came in for a lot of criticism after that happened because she was the face of the department. And the buck stopped with her. And I do think there are a lot of Obama administration people in the Biden administration, so it doesn’t entirely surprise me that there is a similar interest in managing what they perceive to be the most important domestic policy issues through the White House. But I do think there are downsides to that, and I think in the case of covid, there really is a lot of interagency coordination that is important, and those are agencies that are all part of HHS. So I think leaving the Health and Human Services secretary off to the side could be seen as a way of streamlining things but also could be a way of complicating the normal processes by which these different organizations tend to work with one another.

**Rovner:** Yeah, it’s clear that there have been mixed messages, all of them coming out of the Department of Health and Human Services, which presumably could have gone through the secretary’s office. But as you mentioned, Margot, it isn’t even just Obamacare. This goes way back. Big signature presidential initiatives tend to be run out of the White House and not out of their respective departments. That was not unique to Obamacare, that that was centralized through the White House. Although I find it amusingly ironic that the person who’s running the White House covid team is Jeff Zients, who was brought in to fix HHS when Obamacare kind of crashed and burned in the fall of 2013. I think this will go on. Before we leave the Department of Health and Human Services, one news item from this morning, which is that we spoke last week about how the free at-home covid tests that were going to go out were not going to be available to most Medicare patients. Well, apparently, the department has found a way to make that possible, and they have announced this morning that Medicare patients will also be eligible for those free covid tests through a deal with pharmacies. That seemed to be a big, overlooked piece of this that was hanging out there. In some ways, you would think, “Well, they should have done this before they announced the whole thing,” or, “Gee, they fixed this pretty quickly.” Which is it?

**Cohrs:** Right. I mean, it’s not effective immediately, from my reading of the policy.

**Rovner:** I think it's in the spring.

**Cohrs:** But I think one key difference with this policy I at least noticed that could help access is that it’s not a reimbursement program like I think they went with in the private insurance market. They’re working out some sort of payment arrangement with the pharmacies. So I didn’t see a whole lot of details about what exactly lane they found for this, so I’ll be interested to see for the future. But I just want to point out the distinction.

**Rovner:** Yes. But I was sort of ... it’s like you knew they were going to have to fix this. You just didn’t know how long it was going to take. Well, meanwhile, we are 54 weeks into this administration, and there is still no confirmed head of the Food and Drug Administration. Now it seems that the nomination of former FDA

Commissioner Rob Califf is in real trouble, which I will point out we noted here several weeks ago. Rachel and Alice, you both wrote about Califf's woes this week. Rachel, why don't you start with what you found.

**Cohrs:** This week was pivotal just because we were able to talk to lawmakers in the hallway again. It had been a while since we've had that kind of access, to just get their perspective on it. I think my big takeaway was that a lot of lawmakers haven't made up their minds yet, and I think, yes, Congress is doing a lot and they have to take things as they come. But this is also an incredibly important position to have filled, and it's one that's languished for so long. And a lot of these lawmakers were like, "Who? He's not on my committee, so I haven't even thought about him yet." And certainly a lot of this conversation happens at the staff level, too. But I think it'll be interesting to see in the days ahead how quickly some of these key people solidify. I think some of them, obviously publicly it makes sense for them to want to be undecided because they want some outreach. They want a sit-down, some conversations with the White House with some people higher up, that just haven't happened yet. So I think it's definitely not over. It's a question of how aggressively are they going to move forward with this nomination. There's some big questions about the numbers here.

**Rovner:** Alice, we've pointed out that there are some Democrats who have doubts about Califf because of his involvement, or lack thereof, with the opioid crisis and the FDA's easy oversight of opioids when he was commissioner. They were counting on some Republicans supporting him, and now the anti-abortion groups are coming out extremely strongly against him, which kind of puts the squeeze on it, right?

**Ollstein:** Right, exactly. And so the truism about the Hill is when they have the votes, they vote. And the fact that they have not voted on this yet, many weeks after it passed out of committee. Yes, they are busy, of course, but this is a priority for the administration. And so it's clear that the votes just aren't there yet, both from our reporting and from the fact that they haven't scheduled the vote. A couple other developments: Califf did make an ethics pledge about recusing from certain decisions related to industries with which he was involved in the private sector. That helped him secure the support of [Massachusetts Sen.] Elizabeth Warren, and some other senators told me it was also meaningful for them. But I think the fact that they said, "Yes, I appreciate that he did that. That does help alleviate some of my concerns." ... But those people who said that also didn't fully commit to vote for him yet. And so I think that's also telling. On the Republican side, you're seeing people who either supported him the last time he was up for this job or were praising him even just a few weeks ago when the nomination was going through a committee now saying, "I'm not so sure." So it's all not a great sign for him.

**Rovner:** Yes. And I will point out that, as you guys point out, the Senate is here, and they're voting on nominations this week, so if they had the votes, one presumes they would have voted.

**Ollstein:** I mean, complicating all of this, obviously, is the new illness of [New Mexico Sen. Ben Ray] Luján, who had a stroke and will be out for several weeks recovering from that. And if this really comes down to the wire and every single vote matters, that could really delay things as well.

**Rovner:** That's right because the Democrats don't have a working majority with Sen. Luján not here. They only have 49 votes. They can create no ties for the vice president to break.

**Sanger-Katz:** Can I just provide one piece of context? I feel like all of this just makes it even more puzzling why the Biden administration waited so long to nominate someone for this job. The FDA has been a really, really important agency that has had a lot of very high-stakes decisions that it's had to make over the course of the last year about vaccines for covid, about tests for covid, about how to change the regulations around abortion pills and other things. And it has been doing those things in the absence of a permanent, confirmed director, and you would think that they were waiting all this time because they were trying to

get the guy that they could get through, and if Califf cannot be confirmed, I think it just makes their choice not to nominate someone sooner feel even harder to understand.

**Rovner:** Yeah. And the other one of the other truisms on Capitol Hill is that one of the safest nominations is somebody who the Senate has confirmed before, and here's somebody that the Senate has confirmed before. So granted, it's a different Senate, it's a different time. And for a long time, the Senate could not approve an administrator of [the Centers for Medicare & Medicaid Services], not because of who the person was who was nominated, but because of all the other political questions surrounding Medicare and Medicaid. That nomination was always too tempting to block for either side. So I think that's now moved from CMS administrator to the head of the FDA.

All right. Well, let us turn to covid because there is lots of news this week, much of it good for a change. The omicron wave seems to be subsiding, at least in the most hard-hit areas. The FDA officially approved the Moderna vaccine this week, and Pfizer has applied for an emergency authorization to vaccinate the youngest children finally. This has been a long wait for parents of young children not yet eligible, but we are clearly not out of the woods yet. While maybe parents of young children will soon be able to feel some sense of relief, millions of people with compromised immune systems or other disabilities are still effectively in lockdown, either because it's still too dangerous for them to be around other people or because they can't use current mitigation tools like rapid tests if you happen to be blind. Are we just going to go back to quote unquote normal and leave our vulnerable fellow citizens in covid limbo?

**Sanger-Katz:** I think there's one piece of really good, bright news on the horizon that we have talked about before but I think has faded a little bit from the conversation, which is that the FDA has also authorized the use of these very effective antiviral drugs, which, when taken early in the course of illness, seem to really, really reduce the likelihood of hospitalization. They seem to work in people who have these risk factors for serious disease and for people who have not been vaccinated, and it's taken a while for those pills to get manufactured and distributed. There was quite a good story, that I think someone mentioned as their extra credit recently, about a reporter who's trying to get those pills for her mother and just like encountering incredible hurdles. But I think long term or medium term — in a month, in two months, in three months — those pills are going to be available at the pharmacy. Your doctor can prescribe them to you. And so I think what that means is that the stakes of getting infected for the people who really have reason to be concerned are going to be a little bit lower because there's going to be not just the vaccine that doesn't work as well for them as for others, but also these treatments.

**Rovner:** Yeah. And that sort of links to another story that caught my attention this week that also came from NPR, which is about how even if you can get your hands on a covid test — still not easy — you might not want to take it if it means you won't be able to go to work or your kids won't be able to go to school. This is a serious disincentive to get tested and likely at least in part why the easily spreading omicron has spread so widely. Is there any way to fix this, other than to make sure that people have paid leave?

**Ollstein:** The pandemic has just exposed how threadbare the country's social safety net is and just how the government is absolutely not there for people when they have a crisis or an emergency, and people don't even have the means to comply with what the government is telling them to do on the public health front. One of the articles you circulated was about somebody being fired when they got infected with covid when they did the right thing and tested and reported it. No good deed goes unpunished in some circumstances. And so I think there was so much talk of giving these enhanced benefits and protections for workers that many of them have now expired. And the prospects for renewal as part of the Build Back Better package are now extremely uncertain. And so I think as we move forward and we keep saying, "Get tested, report

the results, isolate, do the right thing,” if that makes the difference between someone being evicted, losing their job, not being able to feed their kids, what choice are they going to make?

**Cohrs:** I think it kind of ties into both of the other issues we were just talking about, just the consequences of those incentives, because I think you do have to have a positive covid test to access these antivirals. And I think longer term, if you think about disability, about long covid, we saw so many different questions. And if you're unable to prove that you actually had covid, then I don't know that we know what coverage is going to look like for some of these side effects that we just don't quite understand yet. So there are consequences for these people. But in the moment, these are really difficult choices.

**Rovner:** As I say, we are definitely not out of the woods yet. Go ahead, Alice.

**Ollstein:** I also think there's a lot of oversimplification, both in terms of the public discussion and in terms of policy in some circumstances. There's a very black and white, the unvaccinated can do this and the vaccinated can do that, and it does not take into account the reasons people are maybe vaccinated or unvaccinated, the different levels of vulnerability, even among the vaccinated or among the unvaccinated. And I think applying these sort of blanket policies and lifting restrictions very, very broadly ... I mean, we saw what happened last year. Restrictions were lifted. People were told, if you're vaccinated, you can do this and that and take off your mask. And it really backfired when things got bad again and left a lot of people, even before things got bad again, in a very vulnerable place.

**Rovner:** Well, speaking of things that have backfired. To revisit something else that we have talked about from time to time, it seems that state medical boards that are trying to push back on misinformation and disinformation are themselves getting pushback. In some cases, it's from lawmakers who are trying to rein in the watchdogs who are trying to rein in the rogue doctors, which feels suboptimal, to use one of my favorite Twitter words. In other cases, medical boards don't have the authority to punish doctors who broadcast bad information on social media or elsewhere because most of the regulations are related to the treatment of individual patients. Is this leading us to a point where there could be no consequences for medical bad actors? It kind of reminds me of the early 1900s, when people were out sort of promoting anything they wanted to.

**Ollstein:** Like so many other things, the pandemic has just been so revealing for what the medical community is really like versus what people's assumptions of it are really like. And I think you can look at the members of Congress who are medical professionals to see just the wide variety of attitudes and spreading of misinformation and just the wide range of approaches to medicine and public health. And I think that is reflected in the broader field as well. And people were just flabbergasted that so many medical professionals themselves didn't want to get vaccinated or were not giving patients accurate information about vaccines. And I think it's really ...

**Sanger-Katz:** Although most do.

**Ollstein:** Right, right.

**Sanger-Katz:** I feel with so many of these issues where you see people who are making these anti-vaccination arguments or refusing to take seriously the pandemic in various ways, I think it is important to just highlight that that's unusual. Most doctors did get vaccinated, most doctors are advocating for most of their patients to get vaccinated. But, of course, the small minority who are not and who are noisily promoting these unscientific ideas have a lot of influence. And so that's why we care about that. But it doesn't mean that it's typical.

**Rovner:** And there is legitimate disagreement in the medical and scientific community. There's still so much we don't know about covid. So some of these are not rogue doctors trying to make a buck when they're saying that kids should or shouldn't be in school or that the mental health issues of kids being out of school [are] worse than the possibility of their getting covid in school. And there's an awful lot of disagreement about how best to move forward that is all people taking what it is that we know and applying it and coming up with a different conclusion. And that's different from ... I don't think medical boards are going after those people. I think medical boards are going after people who are clearly not just outside the mainstream, but way outside the mainstream. The problem is the mainstream's gotten really wide.

**Ollstein:** I also think it shows the risks of the messaging from the federal and state level of "Talk to your doctor — if you have questions, talk to your doctor." One, not everyone has a primary care physician, including many people with perfectly good insurance still don't have a primary care doctor or any kind of doctor they actually have a relationship with and feel comfortable talking to. And then, of course, there is the small minority of doctors where if you go talk to them, they will tell you something that is not true. So I think that sort of broad messaging — on the one hand, people listen, people who do have a doctor they have a relationship with will listen to them more than they might listen to another figure on this kind of thing — but there are risks to that strategy as well.

**Sanger-Katz:** I just want to mention one related thing, which is I think we're also starting to see some physicians who are profiteering off of the woes of patients with long covid. This is a condition that is not very well understood by science. And people are suffering and looking for answers and help. And there was [a really good article in Mother Jones](#) a couple of weeks ago from Kiera Butler taking a hard look at one of these physicians who is charging patients tons of money and providing them with treatments that seem to have no evidence really and in some cases to which he has financial ties to the manufacturer. So you just sort of unfortunately have to be on the lookout for physicians who are not ethical even as, again, the majority of doctors are trying to do the right thing here.

**Rovner:** Yeah, the double-edged sword of the profit motive in medicine, which is it can motivate you to do things that will save people's lives and alleviate suffering and motivate you to do things that will just enrich yourself and not help your patient.

Well, I do want to talk about abortion because we have some more breaking news from today. In Tennessee, an appeals court is allowing an abortion ban to take effect. It's like the next Texas. It's not as dramatic a ban as Texas' is, but it's the idea that these abortion laws that are in direct contravention of *Roe v. Wade* are being allowed to go into effect while the Supreme Court is considering whether to leave *Roe* in place. Seems a little irregular. Yes, Alice?

**Ollstein:** So there were many regular things about this case. One, they decided to allow this particular ban to go into effect. And the ban in question here is what's known as a "reason ban." It's a ban on abortion when the abortion is sought for a particular reason. In this case, it's due to the sex, race, or Down syndrome diagnosis of the fetus, and there are a small handful of these laws that have been allowed to take effect in other states. So it's not the first of its kind. But what was really unusual was that the court also said that they were just going to hang on to this and not hold arguments or really fully deal with the case until the Supreme Court decides the fate of *Roe v. Wade*. So it's worth noting that Tennessee is one of the states with what's known as a trigger ban, where if *Roe v. Wade* is overturned by the Supreme Court, abortion will automatically become illegal. So it would make this whole thing moot. But there was a lot of anxiety from a judge who wrote a dissent in this case, that the court was kind of trying to game the system and prevent people from obtaining abortions before that happened while they still could.

**Rovner:** I assume that they're going to call the bluff and take this to the Supreme Court at this point and say, "Are you really going to let this happen before you've delivered your decision in this case?"

**Ollstein:** They well might. There's another petition about a reason ban currently pending before the Supreme Court, but since it already — that's out of Arizona. But since that has already been sitting before the Supreme Court for months, the thinking is that they're also going to just sit on that until they decide on *Roe v. Wade*. So just because you bring something to the Supreme Court doesn't mean they'll necessarily take it. They operate on their own timeline.

**Rovner:** Yes, as we have seen. Well, I had already wanted to talk about abortion this week because I wanted to talk a little bit about how we got to where we are. There was a really interesting [piece in The New York Times](#) by the son of an abortion doctor in Buffalo making the case that a big reason abortion is so unavailable and likely to become even more so is that the medical community itself shied away from embracing it as routine health care. And it's been basically limited to clinics that have been easy for opponents to physically target. I can say it's certainly true that while the medical community is suddenly all about preserving *Roe*, that was not the case in the 1980s and 1990s and even the early 2000s. I'm wondering what you, Alice and Margot, who've both written about this, think of the idea that had the medical community more embraced the availability of abortion, particularly after the abortion pill was approved two decades ago, we'd be in a different place right now.

**Sanger-Katz:** There was a [really fascinating article](#) that my colleague Emily Bazelon wrote for The New York Times Magazine I think a decade ago about this issue, about the way that abortion care in the United States has become increasingly over time concentrated in these clinics. And what was interesting to me about that piece was that it said some of it was about a lack of embrace by mainstream physicians in incorporating abortion care into the normal practice of family medicine or obstetrics and gynecology, but also that there was kind of a feminist push to do it this way, that there was an idea that it would be better for women to be able to seek abortions in these publicly identifiable places, to not have to ask their doctor who may or may not provide abortions, to go to a supportive environment, to have these women's clinics. And there has obviously been a lot of consequences of that. Perhaps some of those goals have been achieved. On the other hand, I think we do see that abortion clinics have become the targets of widespread protest and also of intense regulation that I think would be harder to achieve if abortions were being provided by more doctors throughout the medical community. And I do think with the advent of these new regulations of abortion pills from the FDA, it does raise these questions about whether more medical providers outside of the abortion clinic setting might be able to start providing this service and make abortion a little bit less vulnerable to some of the intense regulations that we're seeing.

**Rovner:** I covered the approval of the abortion pill in 1999 and 2000, and that was the huge fear of the anti-abortion forces, which was that abortion would no longer be primarily available in these clinics and they wouldn't even know where to target it, and yet that sort of didn't happen. Alice, do you want to add something before we move to Margot's piece?

**Ollstein:** The anxiety you just described is the same anxiety that the anti-abortion movement has now about the pills being available for, being prescribed remotely and sent by mail to people's homes, which is you can target clinics, you can protest outside clinics, you can accost people outside clinics, but when it's just coming to millions of private homes, it's harder to go after. And so that that's obviously a plus for the abortion rights side and a downside for the anti-abortion side, although, as we've discussed, states are still able to and are absolutely exercising their ability to put restrictions and bans on the pills.

**Rovner:** So, Margot, the [other interesting piece](#) I saw recently was yours, pointing out that while the U.S. on paper allows abortion much later in pregnancy than many of our peer countries, abortion is actually less

available here, and most other industrialized countries are expanding, rather than constricting, abortion rights. I found this a little bit surprising. Were you surprised when you reported it?

**Sanger-Katz:** I was surprised. There were a number of things that I found really surprising in the reporting. And one thing that I found most surprising is that the argument that anti-abortion litigants made at the Supreme Court and that [Chief] Justice [John] Roberts raised in a question where he said like, “Isn’t the US weird? Aren’t we an outlier?” I think is basically true. I mean, outlier is an exaggeration. There are a number of other countries, and particularly English-speaking countries, it seems that have quite expansive abortion rights until quite late in pregnancy. But when it comes to the *Roe* framework, which basically says abortion is a constitutional right until the point of fetal viability, you just don’t see a lot of countries that have that. You see throughout Europe, countries that have gestational bans. You can have an abortion for any reason up to about 12 to 14 weeks of pregnancy, is kind of the typical limit. And then after that, you still can get an abortion if you have a reason, but you have to have a reason. Different countries have different processes for adjudicating whether your reason is good enough and different kind of norms about how easy it is to get that exception. And you, of course, have to find a provider who is willing to provide an abortion to you later in pregnancy if you get the approval that you need. And so I think in real life, there is quite a bit of variability in these countries that look quite similar on paper in terms of how easy it is to get an abortion later in pregnancy. But there also is a kind of infrastructure around abortion care in a lot of these Western nations that we think of as our peers that we don’t have here. And one of them is this thing that we were just talking about, which is that it seems that in a lot of places in Europe, abortion is just something that normal doctors do, that you get an abortion in the hospital, you get an abortion in a medical clinic. You don’t go to a special place that just does abortions. And so what that means is that there is ... you don’t have these kind of atomized clinics that may be very far from where women live. You tend to have public financing for abortion in these countries, so you don’t have women who are having to save up for a big trip and then for an expensive procedure that their insurance doesn’t cover. And that that system facilitates more women getting abortions earlier in pregnancy. They have a place that they can go that’s nearby and convenient. They have insurance that’s going to pay for their abortion. But if they want to have an abortion late in pregnancy, depending on where they live and the particular circumstances that they face, they may actually have as much or more difficulty in Europe as in the United States.

**Rovner:** And I wouldn’t be surprised if that’s not eventually where the U.S. ends up. I just think that there’s going to be all kinds of throws, political and otherwise, before the U.S. ends up there. Well, speaking of issues that are not settled, but that I’ve been writing about since I was very young, we have news this week that the U.S. Department of Labor is investigating 30 separate employer health plans for failing to obey the mental health parity laws passed in 2008 and in 2010. The federal effort here actually dates back to 1996. But every effort that Congress has made to ensure that people with health insurance get the same level of coverage for mental as they do for other physical health care has been successfully evaded by insurers and employers. Apparently, the Labor Department finally got some better enforcement authority in 2020, which led to the action announced last week. Are we ever going to see actual parity or is this just going to continue as a frustration for patients?

**Ollstein:** This is something that’s really interesting, and I think the new report has kicked off a big round of finger-pointing about who’s at fault for this. You see the providers blasting the insurance companies for violating these parity laws, and you are seeing insurers and employer groups hit back and say, “Oh no, it’s the greedy providers who won’t participate in our insurance networks because they want higher reimbursement rates” and blah blah blah. And I think with so many of these fights — you know, surprise billing comes to mind as a recent one — there is blame to go around, but I am really interested about how these industries, you know, maybe through lobbying or whatnot going forward are going to try to shape whatever solution Congress pursues with this. There was an attempt to enact monetary penalties for



violations of the parity law, and I think the industries who are at risk of getting hit by those penalties are going to do a lot to make sure that does not happen. So it's definitely something to track. And of course, the context is that the pandemic has been horrible for mental health. There are so many indications of things getting much worse, especially for children, adolescents, and many other groups that were already at risk. Opioid use is up. Overdoses are up. And so there is a real need to address this. So we don't we don't want to get lost in the finger-pointing and policy battles and forget what's really going on on the ground.

**Rovner:** Yeah. And when you're in a mental health crisis, you don't want to, you know, I keep seeing stories about people who call 100 providers and they all say, "We can see you next July," which is not really helpful.

**Sanger-Katz:** You know, there also is kind of this structural problem that's like a hangover from all of the many decades in which we did not have mental health parity. And typically, insurance companies did not cover mental health care, which is that we have a mental health care workforce that largely does not participate in health insurance. I think, I could be wrong about this, but I think that psychiatrists and other other kinds of mental health providers are much less likely to accept insurance than medical providers and basically any other medical specialty, except maybe something like plastic surgery. Even if your insurance company is doing everything right and following all of the rules that it can be quite difficult to find a provider who is willing to accept insurance. And so I think that creates additional barriers above and beyond whatever fishy behavior is being done by certain plans. I think there is just ... the mental health care provider landscape just looks very different than for a lot of other kinds of health care. And so I think that can create access problems as well.

**Rovner:** Yes, a continuing frustration. All right. Well, one more this week. From what I'm calling the Department of Duh, California has again failed to pass a bill to create a state single-payer plan. This year, at least there was a proposed financing mechanism, which was to raise taxes on the wealthy. Basically, let Silicon Valley pay for it. But once more for the folks in the back, the state cannot do this on its own, even if it does raise the money for it, right? There's this thing called ERISA (the Employee Retirement Income Security Act of 1974).

**Sanger-Katz:** Yeah, I'm a broken record on this particular matter.

**Rovner:** So am I.

**Sanger-Katz:** So I think you and I could just do a whole podcast about this. But a very large number of people in this country who are working age get their insurance from their employers that are subject to federal and not state regulation. And so that, and the fact that we have Medicare, also a federal program for another huge chunk of Americans — those two groups put together are way more than half of all people living in most states. And so what that means is that anything that the state can do is really not going to be able to get its arms around the entire health care system and is not going to be a single-payer system in the way that we think of it, where everyone is getting the same insurance and the government has control over the providers to some degree because it is paying them all in the same way. Because of that, I just think it is extraordinarily difficult for the states act alone on this.

**Rovner:** But California, I'm sure, will continue to fight about it, because that's what California does. And we will continue to watch it because it's California. All right. Well, finally in the news this week, last week we talked about a very odd lawsuit filed by a hospital in Wisconsin against another hospital, basically across town that had hired away most of its radiology department. Well, the judge said the lawsuit didn't have any merit, and this week the suing hospital dropped its lawsuit. Still, the health staff retention woes are real,

and I'm sure we will talk about them in the weeks to come. So that is the news for this week. Now we will pay my "Bill of the Month" interview with Noam Levey, and then we will come back with our extra credits.

We are pleased to welcome to the podcast my KHN colleague Noam N. Levey, who reported and wrote the latest KHN-NPR "Bill of the Month." Noam, thanks for joining us and welcome to the podcast.

**Levey:** Thank you. Good to be with you, Julie.

**Rovner:** So this month's family is yet another victim of seemingly bizarre emergency room billing. In this case, there wasn't even a doctor directly involved. Tell us who the family is, what happened and what kind of care sent them to the ER.

**Levey:** So the family this month are the Bhatt's who are a young family that live outside St. Louis, Missouri. They're immigrants from India, and Dhaval Bhatt, the father, is a research scientist at Washington University in St. Louis. They went to the emergency room last spring when their toddler burned his hand on the kitchen stove and Dhaval Bhatt, the father, was headed out of town. And the next day, the mom called the pediatrician, sent a photo of the little boy's hand, which looked a little blistered, and the pediatrician told them to go to the hospital. When they went there, they got directed to the emergency room. When they went to the emergency room, they were admitted to the emergency room. A nurse practitioner came and looked at the little boy's hand. They took the kid's vitals, looked him over, and the nurse told the mom that the surgeon who was on call would be over to see the family and take a look at the wound. Well, after about an hour and a half, the mom got a little tired of waiting. Her 2-year-old was apparently bouncing off the walls, and she had a kindergartner at home trying to do Zoom school, and so she left without having seen the doctor. And it turned out that the wound was sufficiently minor, that it healed by itself within a few days, and the family didn't even have to take little Martand Bhatt to see a doctor at all. The burn just healed by itself.

**Rovner:** So they never saw a doctor, and yet they got a bill from the emergency room, right?

**Levey:** They did. They were quite surprised when the bill arrived. It was for \$1,012, which was then discounted to \$858.92 by their insurance company. But needless to say, they were sort of stunned at that amount, considering that they hadn't really gotten any medical care.

**Rovner:** That's right, and they never did see the surgeon. Nobody saw the wound, except for the nurse practitioner, who just looked at it, right?

**Levey:** That's right. And to be clear, a nurse practitioner is a skilled clinician. So if the nurse practitioner had delivered any complex care, that would have been one thing. But, apparently, she really, according to the medical notes and the family, she really just took a quick look at the bandage and the wound. And, as I said, told the family that the surgeon would be over to look at it later.

**Rovner:** So basically, she triaged it and determined that it was not something that needed immediate emergency care and sent them back to wait, which is what happens when you go to the emergency room, yes?

**Levey:** That's right, especially with a lower-severity type issue like this one.

**Rovner:** So they complained about this bill, and what does the hospital tell them?

**Levey:** So Dhaval Bhatt did everything he was supposed to do. He called the hospital. He tried to get an explanation for why they had been charged this. The hospital said this is appropriate. He called his insurance company and he tried to have the insurance company look at it. But the insurance company

wasn't much help. He tried to get in touch with state health officials. They weren't much help, either. And in the course of trying to contest this bill, the hospital sent him to collections. And he actually got a notice from a collection agency that warned him if he didn't pay the bill, that he would be subject to credit rating dings and so forth. So he got quite alarmed, and that's when he wrote to us at Kaiser Health News.

**Rovner:** And what did eventually happen with this bill?

**Levey:** We called the hospital and tried to figure out what was happening. We eventually got an itemized bill sent to the Bhatt's, which indicated what exactly was going on, something that the Bhatt's had not been able to do. The bill that arrived indicated that what was really behind this was something called the facility fee, which is a fee that hospitals charge for, essentially, according to hospital officials, anyway, as a way to cover the overhead of having an emergency room available to the community 24 hours a day. The issue, of course, is whether or not a facility fee is justified if no medical care is provided. The other issue that came to light when we looked at the bill and the itemized bill was how severe this visit had been coded. So when patients go to an emergency room, the patient's condition is rated a Level 1 to a Level 5. And a Level 5 is you come in on a stretcher and you're in a terrible car accident and they have to drop everything to save your life. A Level 1 is maybe you come in with a headache, you're concerned. Maybe you're having a stroke, but it doesn't appear to be anything too serious. The hospital coded Martand Bhatt's visit as a Level 3, which is sort of an intermediate level, which — talking to medical billing experts — is a little bit of a judgment call on the part of the hospital. Could it have been classified as a lower-level visit? It seems that it probably could have. One thing which research has shown in recent years is that there's been quite a systematic increase in how severe hospitals are coding patients. It won't surprise you that when you get coded at a Level 5, the hospital can charge considerably more than they do when you come in at a Level 1. So the issue really was both the fact that they applied a facility fee, even though very little medical care was provided, and how severely they judged that the little boy's wounds were. Those two things together combined to stick this family with this nearly \$1,000 bill.

**Rovner:** Did they end up having to pay it?

**Levey:** So they did not. [Dhaval] Bhatt had told the hospital, "I am perfectly willing to pay you for the service that the nurse provided. I'll even pay you for a lower-severity visit." But the hospital refused to recode the visit. But when we contacted the hospital and asked them to justify their billing practice, at that point, they offered the Bhatt's to discount the facility fee entirely. And so, at that point, [Dhaval] Bhatt paid the hospital just for the nurse practitioner's services, which were billed at a grand total of \$38.92.

**Rovner:** Which seems like not very much for the nurse practitioner.

**Levey:** It certainly doesn't. And I guess we'll leave it to listeners to decide whether or not the comparison between an \$820 facility fee and a \$38.92 fee for what the nurse practitioner does is an equitable distribution of financial responsibility. But it all ended up OK for the family, thank goodness. And they certainly got a fairly sobering lesson in how to approach emergency rooms in the United States.

**Rovner:** Which was my next question. I mean, what is the takeaway here? It seems like an emergency room is like a taxi. The meter starts running when you get in and close the door, even if you don't go anywhere.

**Levey:** I think that's a good analogy, except even in a taxi, it usually ... the meter runs more slowly than if you're actually moving through town. I mean, in this case, you know, I think the caution for patients, as difficult as it is to say this, is to really think twice before going to an emergency room. And physicians will always say, "We don't want to discourage anybody from coming in to get care because even a minor issue can be serious." For example, someone is feeling like they have a headache that won't go away. That can be

a very serious stroke. You don't want people to just ignore that. But it is a caution that when you walk into an emergency room, you are going to start getting charged. It is not like if you go to a restaurant and you wait for a table for an hour and the table never becomes clear and you walk away and you will never be charged. You're going to run up a charge the minute you check into the hospital. So if there's an option to go to an urgent care, if your physician has an after-hours service that they can help you with, unfortunately, many do not. But if that is available, it's almost always better to try to go someplace else, if you can, for urgent care unless it is a real emergency.

**Rovner:** And if you get a huge bill, you can write to us. Noam Levey, thank you very much.

**Levey:** My pleasure. Good to be with you.

**Rovner:** We are back and it's time for our extra-credit segment where we each recommend a story we read this week we think you should read, too. Don't worry if you miss it; we will post the links on the podcast page at khn.org and in our show notes on your phone or other mobile device. Alice, why don't you go first this week?

**Ollstein:** Sure. So I chose [a piece by my colleague Megan Messerly](#) which is about the coming Medicaid crisis whenever the covid-19 public health emergency is officially terminated, which who knows when that will be? And that's part of the problem, and so she is talking to a lot of people at the state level who are warning that up to 15 million people, about half of those being children, are set to lose Medicaid coverage. So, you know, during the pandemic, states were barred from kicking people off Medicaid. And so there is this backlog, and they will start to reevaluate everybody on the rolls once the public health emergency ends and people lose Medicaid eligibility, not just because they might be making too much money to qualify, but just simple paperwork errors just falling through the cracks. And so some states who don't want to have millions of people suddenly uninsured when that happens are right now trying to do some early outreach and contact people and tell them to update their info so they don't lose coverage and tell them, "Hey, if you do lose Medicaid, you can get an Obamacare plan, potentially with subsidies," yadda-yadda-yadda. But, you know, people are hard to reach, and we've seen in the past that people who should have coverage often lose coverage. On the other side, you have states who want to save money and not pay for all these people's Medicaid, who are expected to move swiftly and aggressively to kick people off in order to save [thousands of] dollars. And so there's concern about that as well. And so this is sort of a preview of the chaos to come.

**Rovner:** Yeah, this could be a big story for 2022. Rachel.

**Cohrs:** Yes. So my extra credit this week was written by my colleague Casey Ross. And the headline is "[How a Decades-Old Database Became a Hugely Profitable Dossier on the Health of 270 Million Americans](#)." And I think it just kind of breaks down this company called MarketScan, and it's a really, I think, illuminating conversation with its founder, you know, he founded this company decades ago and has been, you know, really alarmed by what it's become, how much other information is out there that allows these companies to augment that the health care data that they already have and the potential just for consumers to completely lose control of their data. And it is just a really interesting piece in this larger saga of IBM's Watson [Health] being sold off. And I think this is one of the more valuable assets that a private equity firm now owns. So I think it's really ...

**Rovner:** And just a reminder that, you know, when someone says, "Do you care if we use your information?" and you say, "Yeah, sure," that that information can then get sold to somebody else who you might not trust as much as whoever you first gave permission to. So, I mean, everybody's information is floating around out there. (Not always.)

**Cohrs:** And it all ends up in the same place.

**Rovner:** Margot.

**Sanger-Katz:** I wanted to recommend a story from Kaiser Health News that's actually very closely related, I think, to Alice's story, called "[Faxes and Snail Mail: Will Pandemic-Era Flaws Unleash Improved Health Technology?](#)" by Bram Sable-Smith. This piece just really points out all of the kind of rickety technology that is used for all kinds of health care and also for government services. And I think it gets at a theme that Alice mentioned earlier about, like, we have this very porous social safety net where there's lots of problems and we saw early in the pandemic, you know, state unemployment websites just imploding as people were trying to apply for benefits. And we see quite frequently, when we don't have these emergency measures in place, people routinely losing their Medicaid benefits because some computer program mismatched their data from one database and another one and came to think that they were at the wrong address or that their income had changed when it hadn't or whatever. And I reported with my colleague Sarah Kliff earlier in the pandemic about how a lot of public health test results were being communicated via fax, a technology that no one uses outside of health care anymore. And I think this piece just does a nice job of showing all of the ways that our health care system and our public health insurance systems are relying on poor and outdated technologies. And there has been no shortage of federal dollars to try to bolster all of this. The Affordable Care Act, in particular, gave states very, very generous terms to update their Medicaid technology systems, and lots of dollars were spent on that. And yet we still see in a lot of states really problematic systems. Some of them are in these states that are sort of disinclined to keep a lot of people in these public programs anyway. But I don't think that they intentionally bought bad systems. I think they just have encountered a lot of technology problems that they have been unable to solve. So, anyway, this is sort of a perennial frustration of mine, both because I just don't understand why we use fax machines anymore and also because I think that good technology could really help people navigate these systems, get the coverage that they need, and get the care that they need. And bad technology just stymies them. It ends up discouraging people and making it harder for them. And, you know, that difficulty can really be a problem if they're a vulnerable person who doesn't have a lot of resources to try to fix it themselves.

**Rovner:** And this is not a partisan thing, this is also something that, you know, HHS has made ... interoperability has been a priority since the late 1990s. I mean, since we, basically, first had the internet and electronic medical records — it's not like they didn't know this was coming. It's just they haven't been able to solve the problem. All right. Well, my story this week is by Adam Taylor of The Washington Post. It's called "[Researchers Are Asking Why Some Countries Were Better Prepared for Covid. One Surprising Answer: Trust.](#)" This is a question I've been asking since the start of the pandemic. Did other countries have better health delivery systems, better public health systems, more effective communications, smarter government officials? Because it seems that every time we look to a country that seemed to be doing better than others, the obvious reasons for that were unclear. And sometimes those change. Countries that were doing well at the beginning had their own problems later and vice versa. Clearly, I'm not the only one asking this question. A group of researchers from the Council [on] Foreign Relations and the University of Washington took a deep look and found, according to a study in the British medical journal The Lancet, quote, "no link between covid outcomes and democracy, populism, government effectiveness, universal health care, pandemic preparedness metrics, economic inequality or trust in science." So, what *did* point to greater success? Well, it should have been obvious, but trust in government. If people believe their government officials have their best interests at heart, they're more likely to do what the government then recommends. How do we fix that here? I have no idea, but it certainly explains a lot. It's a really interesting piece about a really interesting study.

OK, that is our show for this week. As always, if you enjoy the podcast, you can subscribe wherever you get your podcasts. We'd appreciate it if you left us a review — that helps other people find us, too. Special thanks, as always, to our ace producer, Francis Ying. Also, as always, you can email us your comments or questions. We're at whatthehealth — all one word — at kff.org. Or you can tweet me. I'm @jrovner. Rachel?

**Cohrs:** @rachelcohrrs

**Rovner:** Margot.

**Sanger-Katz:** @sangerkatz

**Rovner:** Alice.

**Ollstein:** @AliceOllstein

**Rovner:** We will be back in your feed next week. Until then, be healthy.